

TO BE GIVEN TO PERSON  
EXAMINED WITH A PRE-  
ADDRESSED "CONFIDEN-  
TIAL-MEDICAL" ENVELOPE.

# UNITED STATES CIVIL SERVICE COMMISSION CERTIFICATE OF MEDICAL EXAMINATION

Form Approved  
Budget Bureau  
No. 50-R0073

## Part A. TO BE COMPLETED BY APPLICANT OR EMPLOYEE (type or print in ink)

1. NAME (last, first, middle)	2. SOCIAL SECURITY ACCOUNT NO.	3. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	4. DATE OF BIRTH
5. DO YOU HAVE ANY MEDICAL DISORDER OR PHYSICAL IMPAIRMENT WHICH WOULD INTERFERE IN ANY WAY WITH THE FULL PERFORMANCE OF THE DUTIES SHOWN BELOW? <input type="checkbox"/> YES <input type="checkbox"/> NO (If your answer is YES explain fully to the physician performing the examination)		6. I CERTIFY THAT ALL THE INFORMATION GIVEN BY ME IN CONNECTION WITH THIS EXAMINATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF  (signature of applicant)	

## Part B. TO BE COMPLETED BEFORE EXAMINATION BY APPOINTING OFFICER

1. PURPOSE OF EXAMINATION <input type="checkbox"/> PREAPPOINTMENT <input type="checkbox"/> OTHER (specify)	2. POSITION TITLE Offset Duplicating Press Operator, WG-4417-07	
3. BRIEF DESCRIPTION OF WHAT POSITION REQUIRES EMPLOYEE TO DO Sets up and operates a duplicator and other special printing equipment to print overlays and charts. Operates a variety of bindery machines and other machines such as paper drill, staple, punch, to bind printed material. Programs electronic control center to make proper reductions of originals, copy quality, shifting of images for finished sizes. Handle different solvents and flammable liquids. Light to moderate physical exertion is required.		
4. Circle the number preceding each functional requirement and each environmental factor essential to the duties of this position. List any additional essential factors in the blank spaces. Also, if the position involves law enforcement, air traffic control, or fire fighting, attach the specific medical standards for the information of the examining physician.		
<b>A. FUNCTIONAL REQUIREMENTS</b>		
1. Heavy lifting, 45 pounds and over <input checked="" type="checkbox"/> 2. Moderate lifting, 15-44 pounds 3. Light lifting, under 15 pounds 4. Heavy carrying, 45 pounds and over <input checked="" type="checkbox"/> 5. Moderate carrying, 15-44 pounds 6. Light carrying, under 15 pounds 7. Straight pulling (    hours) 8. Pulling hand over hand (    hours) 9. Pushing (    hours) 10. Reaching above shoulder 11. Use of fingers <input checked="" type="checkbox"/> 12. Both hands required <input checked="" type="checkbox"/> 13. Walking ( 1 hours) <input checked="" type="checkbox"/> 14. Standing ( 7 hours)	15. Crawling (    hours) <input checked="" type="checkbox"/> 16. Kneeling (    hours) <input checked="" type="checkbox"/> 17. Repeated bending (    hours) 18. Climbing, legs only (    hours) 19. Climbing, use of legs and arms <input checked="" type="checkbox"/> 20. Both legs required 21. Operation of crane, truck, tractor, or motor vehicle 22. Ability for rapid mental and muscular coordination simultaneously 23. Ability to use and desirability of using firearms 24. Near vision correctable at 13" to 16" to Jaeger 1 to 4	25. Far vision correctable in one eye to 20/20 and to 20/40 in the other 26. Far vision correctable in one eye to 20/50 and to 20/100 in the other 27. Specific visual requirement (specify) 28. Both eyes required 29. Depth perception <input checked="" type="checkbox"/> 30. Ability to distinguish basic colors <input checked="" type="checkbox"/> 31. Ability to distinguish shades of colors 32. Hearing (aid permitted) 33. Hearing without aid 34. Specific hearing requirements (specify) 35. Other (specify)
<b>B. ENVIRONMENTAL FACTORS</b>		
1. Outside 2. Outside and inside 3. Excessive heat 4. Excessive cold 5. Excessive humidity 6. Excessive dampness or chilling 7. Dry atmospheric conditions <input checked="" type="checkbox"/> 8. Excessive noise, intermittent <input checked="" type="checkbox"/> 9. Constant noise 10. Dust	11. Silica, asbestos, etc. 12. Fumes, smoke, or gases <input checked="" type="checkbox"/> 13. Solvents (degreasing agents) 14. Grease and oils 15. Radiant energy 16. Electrical energy 17. Slippery or uneven walking surfaces <input checked="" type="checkbox"/> 18. Working around machinery with moving parts 19. Working around moving objects or vehicles	20. Working on ladders or scaffolding 21. Working below ground 22. Unusual fatigue factors (specify) 23. Working with hands in water 24. Explosives 25. Vibration 26. Working closely with others <input checked="" type="checkbox"/> 27. Working alone 28. Protracted or irregular hours of work 29. Other (specify)

## Part C. TO BE COMPLETED BY EXAMINING PHYSICIAN

1. EXAMINING PHYSICIAN'S NAME (type or print)	3. SIGNATURE OF EXAMINING PHYSICIAN
2. ADDRESS (including ZIP Code)	(signature) (date) IMPORTANT: After signing, return the entire form intact in the pre-addressed "Confidential-Medical" envelope which the person you examined gave you.

NOTE TO EXAMINING PHYSICIAN: The person you are about to examine will have to cope with the functional requirements and environmental factors circled on the other side of this form. Please take them, and the brief description of job duties above them, into consideration as you make your examination and report your findings and conclusions.

1. HEIGHT: \_\_\_\_\_ FEET, \_\_\_\_\_ INCHES.

WEIGHT: \_\_\_\_\_ POUNDS.

2. EYES:

(A) Distant vision (Snellen): without glasses: right 20 left 20 ; with glasses, if worn: right 20 left 20

(B) What is the longest and shortest distance at which the following specimen of Jaeger No. 2 type can be read by the applicant? Test each eye separately.

Jaeger No. 2 Type \_\_\_\_\_  
employees in the Federal classified service as may be requested by the Civil Service Commission or its authorized representative. This order will supplement the Executive Orders of May 29 and June 18, 1923 (Executive Order, September 4, 1924).

without glasses:

with glasses, if used:

R. \_\_\_\_\_ in. to \_\_\_\_\_ in.

R. \_\_\_\_\_ in. to \_\_\_\_\_ in.

L. \_\_\_\_\_ in. to \_\_\_\_\_ in.

L. \_\_\_\_\_ in. to \_\_\_\_\_ in.

(C) Color vision: Is color vision normal when Ishihara or other color plate test is used? ☐ YES ☐ NO

If not, can applicant pass lantern, yarn, or other comparable test? ☐ YES ☐ NO

3. EARS: (Consider denominators indicated here as normal. Record as numerators the greatest distance heard.)

Ordinary conversation:

Audiometer (if given):

250	500	1000	2000	3000	4000	5000	6000	7000	8000

RIGHT EAR \_\_\_\_\_; LEFT EAR \_\_\_\_\_  
20 ft. 20 ft.

4. OTHER FINDINGS: In items a through l briefly describe any *abnormality* (including diseases, scars, and disfigurements). Include brief history, if pertinent. If normal, so indicate.

a. Eyes, ears, nose, and throat (including tooth and oral hygiene)

e. Abdomen

b. Head and back (including face, hair, and scalp)

f. Peripheral blood vessels

c. Speech (note any malfunction)

g. Extremities

d. Skin and lymph nodes (including thyroid gland)

h. Urinalysis (if indicated)

Sp. gr. \_\_\_\_\_ Sugar \_\_\_\_\_ Blood \_\_\_\_\_

Albumen \_\_\_\_\_ Casts \_\_\_\_\_ Pus \_\_\_\_\_

i. Respiratory tract (X-ray if indicated)

j. Heart (size, rate, rhythm, function)

Blood pressure \_\_\_\_\_

Pulse \_\_\_\_\_

EKG (if indicated)

k. Back (special consideration for positions involving heavy lifting and other strenuous duties)

l. Neurological and mental health

CONCLUSIONS: Summarize below any medical findings which, in your opinion, would limit this person's performance of the job duties and/or would make him a hazard to himself or others. If none, so indicate.

☐ No limiting conditions for this job

☐ Limiting conditions as follows:

**FOR AGENCY USE ONLY**

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5. DO YOU HAVE ANY MEDICAL DISORDER OR PHYSICAL IMPAIRMENT WHICH WOULD INTERFERE IN ANY WAY WITH THE FULL PERFORMANCE OF THE DUTIES SHOWN BELOW?  <input type="checkbox"/> YES <input type="checkbox"/> NO  (If your answer is "YES" explain fully to the physician performing the examination)	6. I CERTIFY THAT ALL THE INFORMATION GIVEN BY ME IN CONNECTION WITH THIS EXAMINATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF  _____ (signature of applicant)		

**Part D. TO BE COMPLETED BY AGENCY MEDICAL OFFICER (if one is available)**

**NOTE: Review the attached certificate of medical examination and make your recommendations in item I below. If the medical examination was done for pre-appointment purposes, circle the appropriate handicap code in part F.**

1. RECOMMENDATION: <input type="checkbox"/> HIRE OR RETAIN. DESCRIBE LIMITATIONS, IF ANY, HERE.          <input type="checkbox"/> TAKE ACTION TO SEPARATE OR DO NOT HIRE. EXPLAIN WHY.		
2. AGENCY MEDICAL OFFICER'S NAME ( <i>type or print</i> )	3. LOCATION ( <i>city, State, ZIP Code</i> )	4. DATE

**Part E. TO BE COMPLETED BY AGENCY PERSONNEL OFFICER**

NOTE: Enter the action taken below. If this form is used for pre-appointment purposes, be sure the appropriate handicap code in Part F is circled.  
**IMPORTANT:** See FPM Chapter 293, Subchapter 3; FPM Chapter 339 and FPM Supplement 339-31 for disposition and/or filing of both parts of this form, either separately or together.

<b>1. ACTION TAKEN:</b> <input type="checkbox"/> HIRED OR RETAINED. <input type="checkbox"/> NON-SELECTED FOR APPOINTMENT, OR ELIGIBILITY OBJECTED TO. <input type="checkbox"/> ACTION TAKEN TO SEPARATE.		
<b>2. AGENCY PERSONNEL OFFICER'S NAME</b> ( <i>type or print</i> )	<b>3. SIGNATURE</b>	<b>4. DATE</b>

**Part F. HANDICAP CODE** *(to be completed only in pre-appointment cases)*

If the person examined has or had a handicap listed below, circle the code number which pertains to that handicap. If more than one handicap applies, circle the one considered most limiting. If none of the handicap codes apply, circle code "00".

- |   |   |  |
|---|---|--|
| 00 No handicap of the type listed                         | 40 Hearing aid required   | 52 Diabetes—controlled   |
| 10 Amputation—one major extremity                         | 41 No usable hearing  | 53 Epilepsy—adequately controlled  |
| 11 Amputation—two or more major extremities               | 42 No usable hearing, with speech malfunction   | 54 History of emotional behavioral problems requiring special placement effort |
| 20 Deformity or impaired function—upper extremity         | 43 Normal hearing, with speech malfunction  | 55 Mentally retarded   |
| 21 Deformity or impaired function—lower extremity or back | 50 Tuberculosis—inactive pulmonary  | 56 Mentally restored   |
| 30 Vision—one eye only                                    | 51 Organic heart disease ( <i>compensated</i> )—valvular, arrhythmia, arteriosclerosis, healed coronary lesions |  |
| 31 No usable vision                                       |   |  |

1. EXAMINING PHYSICIAN'S NAME <i>(type or print)</i>	3. SIGNATURE OF EXAMINING PHYSICIAN
2. ADDRESS <i>(including ZIP Code)</i>	<div style="display: flex; justify-content: space-between;"> <div>_____</div> <div>_____</div> </div> <div style="display: flex; justify-content: space-between;"> <div><i>(signature)</i></div> <div><i>(date)</i></div> </div> <p><b>IMPORTANT:</b> After signing return <i>the entire form intact</i> in the pre-addressed "Confidential-Medical" envelope which the person you examined gave you.</p>